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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

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QUESTION PRESENTED

Whether an arrangement by which a hospital chooses only one group of physicians to render all anesthesia services at the hospital is a *per se* illegal tying arrangement under Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976).

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BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

Amicus Curiae American Hospital Association respectfully presents this brief in support of the Petitioners on the merits of the instant matter. The American Hospital Association has obtained the written consent of both the Petitioners and the Respondent to the filing of this *amicus curiae* brief.

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is "to promote the welfare of the public through its leadership and its assistance to its members in the provision of better health services for all people." Its membership includes approximately 6,300 hospitals and other health care in-

The AHA has an historical commitment to the principle of quality health care for hospital patients, while recognizing that the containment of hospital costs is vital to the continued ability of hospitals to provide that quality care. Hence, the AHA traditionally has undertaken to assist its members in their efforts to achieve the delivery of cost-effective, high quality health care services. Because a hospital itself obviously is not a practitioner of medicine, its relationships with physicians are of critical importance to its success in achieving that goal, and to the ability of the hospital's governing board to discharge its own ultimate responsibility—imposed by federal Medicare program participation requirements, by voluntary accreditation standards, and, increasingly, by common law—for the composition and services of its medical staff.

The AHA recognizes that sound medical care is being provided in hospitals by physicians under a variety of staffing arrangements and does not recommend or endorse any specific arrangement as the best means in all circumstances to provide hospital or medical services. *See* American Hospital Association, *Guidelines: Contractual Relationships Between Hospitals and Physicians* (1976). However, many of AHA's member hospitals, in the exercise of their professional judgment, maintain exclusive arrangements with physicians as a means to serve important interests of the hospital and the community, and confer significant benefits on patients. Exclusive arrangements are particularly prevalent with respect to the provision of necessary, "ancillary" hospital services—anesthesiology, radiology, pathology and emergency room services—for the availability and quality of which hospitals bear an independent and judicially-recognized accountability to their patients.

The AHA further believes that an exclusive arrangement of the type at issue in this case also can serve to foster, rather than inhibit, competition in the health care marketplace. Consequently, the AHA strongly supports the right of hospitals to

maintain the flexibility to enter into an exclusive arrangement with a physician or physician group if the hospital determines that such a staffing arrangement best allows it to serve the interests of its patients. The decision below, through the automatic application of the *per se* rule in this setting, is erroneous, and improperly interferes with that flexibility.

SUMMARY OF THE ARGUMENT

Exclusive staffing arrangements are used extensively by hospitals in the provision of anesthesiology and other necessary hospital-based medical services, and can be critical to hospitals' ability to discharge recognized legal obligations toward their patients and to provide cost-effective, quality patient care.

Amicus curiae American Hospital Association respectfully submits that the judgment of the United States Court of Appeals for the Fifth Circuit, declaring invalid an exclusive staffing arrangement for the provision of anesthesiology services, is erroneous and should be reversed for several reasons. First, the court below erred in finding that the arrangement at issue is a tying arrangement, in that only one product—surgical procedures— actually is being sold. Second, the decision conflicts with previous decisions of this Court with respect to the circumstances in which the *per se* standard of antitrust analysis should apply, because the type of arrangement here can result in a productively efficient and procompetitive type of vertical integration and is not a "naked restraint of trade." Third, the Fifth Circuit erred in finding that the hospital had appreciable economic power in the market for the alleged tying product and therefore erred in finding a *per se* violation of Section 1 of the Sherman Act.

ARGUMENT

I. Introduction—Importance Of Exclusive Staffing Arrangements To The Hospital Field

a. In General

As recognized by the district court below, as well as other courts that have considered exclusive arrangements of the type at issue herein, the use of such arrangements is widespread within the hospital field. 513 F. Supp. 532, 540 (E.D. La. 1981) (it is a "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians"). *See also Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1351 (7th Cir. 1982) ("exclusive dealing arrangement[s] ... [have] been adopted by most hospitals in the Chicago area").

The prevalence of exclusive arrangements reflects both growing specialization and increasing sophistication in the delivery of medical services, as well as the ability of the arrangements to address important needs with respect to the delivery of such services. Specifically, such arrangements allow hospitals to secure and maintain continuously available, high quality medical services; to secure administrative services necessary to the effective and efficient operation of the subject department; and to lower the hospital's operating costs.

Hospitals today inevitably must utilize contractual arrangements, many of which are exclusive in nature, to ensure the provision of an increasing number of medical specialty services including, among others, nuclear medicine, renal dialysis and cardiac catheterization. However, the use of exclusive arrangements is especially prevalent nationwide with respect to the provision of hospital-based ancillary services—anesthesiology, radiology, pathology and emergency room services. As their name implies, ancillary services are provided in support of the primary service for which the patient is in the hospital. For example, anesthesia is one of the many services that are essential but 'ancillary' to the provision of the surgical services

for which the patient has been admitted, and thus is viewed by most patients as part of the surgical procedure. Patients in fact do not choose the physicians or other health professionals who will provide those necessary ancillary care services. *See Dos Santos*, 684 F.2d at 1354; *United States* v. *American Society of Anesthesiologists*, 473 F. Supp. 147, 160 (S.D.N.Y. 1979) ("there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist"). Instead, they rely upon others—e.g., their individual surgeons and, ultimately, the hospital itself—both to make informed choices of ancillary care physicians for them, and, in effect, to vouch for the quality of the services provided.

The necessity of the ancillary services, combined with the absence of physician selection by the patient, has led courts to recognize the special legal obligation of the hospital to ensure the availability and quality of those services. *E.g.*, *Dos Santos*, 684 F.2d at 1354; *Capili* v. *Shott*, 487 F. Supp. 710, 712 (S.D. W. Va. 1978), *aff'd*, 620 F.2d 438 (4th Cir. 1980) ("[t]hese are the services a hospital must guarantee as available to all patients ...[;] [b]ecause the hospital patients do not select the physicians rendering these services and generally do not even know the names or qualifications of these physicians, the hospital has a greater burden of responsibility in assuring the proper quality and quantity of such services"). *Cf. Smith* v. *Northern Michigan Hospitals, Inc.*, [1983-1] Trade Cas. (CCH) ¶ 65,289, at 69,708 (6th Cir. Mar. 25, 1983) (the hospital, "as the coordinator and supplier of an essential ... public service, ... not only may, but also is obliged, to staff its limited [emergency] facilities in the manner which best serves the public interest"). *See also* HHS Medicare Conditions of Participation, 42 C.F.R. § 405.1011 *et seq.* (1977); Joint Commission on Accreditation of Hospitals ("JCAH"), *Accreditation Manual for Hospitals* (1982), for specific requirements imposed on hospitals for the provision of ancillary medical services.

b. Quality and Efficiency Benefits

Many hospitals have determined that, in light of their own individual circumstances and experience, exclusive arrangements provide the most effective and often the *only* means to ensure both the continuous availability of medical services and the quality of those services. One essential characteristic of exclusive arrangements between hospitals and physicians is precisely that the physicians contractually guarantee the hospital twenty-four hour coverage of the subject service as a necessary aspect of their responsibility, which in turn requires or makes desirable that the physicians' relationship be an exclusive one. Physicians cannot feasibly provide assurances of coverage or quality where the service responsibilities are fragmented.

In the absence of a contractual guarantee of continuous coverage, a hospital is likely to experience situations where anesthesiologists, for example, are unavailable for surgery either because of sickness, vacation, or time limitations. *See Capili*, 487 F. Supp. at 711, 712 (prior to contracting exclusively, hospital attempted to ensure coverage through "on call" services of anesthesiologists, which proved "inadequate to insure proper patient care"; JCAH annual review of hospital under "on call" arrangement indicated "deficiencies" in provision of anesthesia services). As specifically found by the district court in the instant case, an exclusive arrangement assures the hospital twenty-four hour coverage of the subject service, 513 F. Supp. at 540; *see also, e.g., Dos Santos*, 684 F.2d at 1351; *Capili*, 487 F. Supp. at 712, and thus assists the hospital both to ensure proper patient care and to avoid potential liability based on inadequate rendering of that care.

In addition, courts (including the district court below), commentators and hospitals have recognized that exclusive arrangements produce numerous other, specific patient care and efficiency-related benefits which may be unattainable except by use of an exclusive arrangement but which also are

crucial to the hospital's ability to discharge its own responsibilities concerning the quality and availability of medical services. *See generally* M. Pollard & R. Leibenluft, *Antitrust and the Health Professions; Policy Planning Issues Paper* (Federal Trade Commission, 1981); Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535 (1982). In general, those benefits flow from the exclusive contract's specific provision for the unified responsibility and accountability of a limited number of physicians to the hospital's governing board for the quality of all services rendered, as well as the physicians' typical contractual responsibility for the complete management of the hospital department, including the provision of supervisory, training and administrative services essential to the most effective and efficient delivery of the subject service.

Among the many additional benefits resulting from an exclusive arrangement between a hospital and a physician group is the hospital's increased ability to monitor continuously the performance of the contracting physicians to ensure that medical quality standards are being met. *See, e.g.*, M. Pollard & R. Leibenluft, *supra*, at 97; Foster, *supra*. Also, the exclusive arrangement often serves to foster greater physician competence, due to increased specialization with attendant development of skills through repetition of specialized procedures. *Id.*

In addition, because the terms of exclusive arrangements typically are for short periods of time and/or are terminable on short notice, a hospital dissatisfied with the performance of the contracting physicians can terminate the arrangement and contract with others. *Cf. Dos Santos*, 684 F.2d at 1354 (exclusive arrangements "may also serve to benefit competition among anesthesiology groups[,] . . . encourag[ing] anesthesiologists to improve the quality of their services in order to obtain these contracts") (quoting the district court herein, 513 F. Supp. at 541).

Further, caselaw emphasizes that exclusive arrangements facilitate improved scheduling in the use of facilities and support staff. *E.g., Capili*, 487 F. Supp. at 712 ("advantages of the exclusive arrangement [for provision of anesthesia services] ... included the efficient scheduling of surgery"). Procedures are done best, most reliably and most efficiently when access to facilities and equipment is planned in advance. Such planning typically is one of the specific contractual obligations of the physician group, and is simplified when coordinated through that single group. For example, a hospital that maintains an exclusive arrangement with an anesthesiology group secures unified responsibility for the scheduling of operating room usage, effectively minimizing the delays and conflicts that arise when a hospital must accommodate the personal scheduling wishes of multiple independent practitioners.

Exclusive arrangements also provide greater control and standardization of procedures, thereby allowing lower operating costs. *See, e.g.*, M. Pollard & R. Leibenluft, *supra*, at 97; Foster, *supra*. More effective selection, use and maintenance of equipment also results. *See, e.g., Capili*, 487 F. Supp. at 712 ("advantages of the exclusive arrangement ... included ... the uniform selection and use of anesthesia equipment and gasses"). For example, the use of costly and sophisticated equipment by only one group tends to minimize the number of equipment breakdowns and facilitates recognition and remedy of malfunctions that do occur. Further, an exclusive arrangement directly facilitates improved work routines and teamwork because physicians both work consistently with and have a specific contractual obligation to supervise a particular group of nurses and technicians, whose services also are crucial to the effective and efficient delivery of the subject service. *See generally* M. Pollard & R. Leibenluft, *supra*, at 97; Foster, *supra*.

Finally, then, and as a result of the many benefits discussed above, the hospital is able to earn an enhanced reputation for

excellence, thus enabling it to attract top flight physicians. *Id.* Given the increased willingness of courts to hold hospitals liable for negligently granting staff privileges to unqualified physicians, *see, e.g., Elam* v. *College Park Hospital,* 183 Cal. Rptr. 156 (Cal. App. 1982), this consideration is particularly important if the hospital is to minimize its vulnerability to malpractice litigation. In addition, however, the ability of the hospital to compete also is enhanced given that hospitals traditionally have competed on a non-price basis to provide the best *quality* of patient care. *E.g., Robinson* v. *Magovern,* 521 F. Supp. 842, 919 (W.D. Pa. 1981), *aff'd mem.,* 688 F.2d 824 (3d Cir.), *cert. denied,* 103 S. Ct. 302 (1982) (closed staff system may promote competition among hospitals resulting in improved quality of patient care). *See Dos Santos,* 684 F.2d at 1354 ("competition among the hospitals in the market [may be enhanced] by increasing the quality of medical care available") (quoting the decision of the district court herein, 513 F. Supp. at 541).

Thus, it is apparent that a hospital has a strong independent interest in maintaining exclusive arrangements with physicians. Demonstrable benefits obtained by the use of such arrangements directly assist the hospital to discharge its legal and professional obligation to its patients to ensure continuously available, high quality health care, and assist it to compete effectively with other hospitals.

II. The Fifth Circuit Erred In Characterizing The Alleged Restraint As A Tying Arrangement

a. A pragmatic economic examination of the agreement between the hospital and the anesthesiology group shows that the Fifth Circuit erred fundamentally in characterizing the arrangement as a tying agreement rather than as an exclusive dealing contract. The hospital, which is responsible for ensuring the provision and quality of anesthesia services, serves as an agent on behalf of its surgical patients to choose the supplier of one component used to produce the service desired by its

patients—that is, surgical procedures. *Cf. Dos Santos*, 684 F.2d at 1354 ("[i]t may ... be more appropriate for antitrust purposes to treat the *hospital* as the purchaser" of anesthesia services because, *inter alia*, the patient generally takes no part in selection of anesthesiologist and hospital bears a legal responsibility for the availability and quality of the services rendered). The arrangement promotes efficiency in the purchase and delivery of anesthesia services and ensures that patients, who typically are unable to choose their anesthesiologist, are served by highly qualified professionals.

Determining the nature of the alleged restraint is a crucial first step because "the characterization of a practice as a requirements contract or as a tying arrangement can determine the result in a case." Baker, *The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot*, 66 Va. L. Rev. 1235, 1308-09 (1980). Several factors should be examined in characterizing the arrangement. First, tying arrangements typically require the purchaser to buy a product that he or she ordinarily would not purchase. *See Heatransfer Corp.* v. *Volkswagenwerk, A.G.*, 553 F.2d 964 (5th Cir. 1977), *cert. denied*, 434 U.S. 1087 (1978). This factor is not present in this case because a patient has no desire to purchase the use of a hospital's surgical facilities without the services of an anesthesiologist or anesthetist.

Second, the presence of procompetitive benefits, as here, undermines the conclusion that the arrangement is a tying agreement. This is because "tying agreements serve hardly any purpose beyond the suppression of competition," *Standard Oil Co.* v. *United States*, 337 U.S. 293, 305-06 (1949), while exclusive contracts achieve efficiencies and other procompetitive benefits. *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320 (1961). Accordingly, if the arrangement in question achieves, or has the potential to achieve, significant procompetitive benefits, then it should be analyzed as an exclusive dealing arrangement. The district court below found that the exclusive

contract did achieve such benefits. 513 F. Supp. at 540. The Fifth Circuit believed that less restrictive alternatives could achieve similar results, although there was little in the record to support this conclusion.[1]

Third, the purpose for the arrangement aids in determining whether it is an exclusive dealing agreement or a tying arrangement.[2] The focus of the tying doctrine is on "practices employed to impede competition on the merits." *Hirsh* v. *Martindale-Hubbell, Inc.*, 674 F.2d 1343 (9th Cir.), *cert. denied*, 103 S. Ct. 305 (1982). Where, as here, the purpose for the agreement is to promote quality or achieve efficiencies, the tying characterization is likely to be incorrect.[3]

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[1] The least restrictive alternative doctrine is a curious sidetrack to mainstream antitrust jurisprudence. Where the spectrum of choices a businessperson can make is *infinite*, to require the business to recognize and choose *the* least restrictive alternative, especially as judged by a court in hindsight, would appear itself to be an unreasonable restraint. *Cf.* American Motor Inns, Inc. v. Holiday Inns, Inc., 521 F. 2d 1230, 1249-50 (3d Cir. 1975) (rejecting the doctrine). *See also* Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 58 n.29 (1977) ("the location restriction used by Sylvania was neither the least nor the most restrictive it could have used[;] [b]ut ... a *per se* rule based on the nature of the restriction is, in general, undesirable").

[2] Examining the purpose for a practice prior to characterizing that practice does no violence to the concept of a *per se* rule. *See, e.g.*, Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 9, 19 (1979); Jacobi v. Bache & Co., Inc., 377 F. Supp. 86 (S.D.N.Y. 1974), *aff'd*, 520 F.2d 1231 (2d Cir. 1975), *cert. denied*, 423 U.S. 1053 (1976). *See also* L. Sullivan, *Handbook of the Law of Antitrust* § 74, at 199-200 (1977).

[3] The Fifth Circuit found that the hospital's rationale in using the exclusive contract was to increase its own profit. 686 F.2d at 291 & n.7. This conclusion, which rejected a specific holding of the district court to the contrary (513 F. Supp. at 544), was based only on sheer speculation and not the evidence. The evidence showed that quality of care and productive efficiency were the hospital's overriding purposes in contracting with only one group. Nevertheless, a purpose to increase profits is not an anticompetitive purpose.

Fourth, it also is relevant to consider whether any other court has characterized a contract similar to the one in question as a tying arrangement. The fact that none has at a minimum suggests that the tying characterization is improper. *See, e.g., Smith, supra; Dos Santos, supra; Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976); *Valley Hospital Medical Center Foundation* v. *Adolph*, No. 79-3336 MRP (C.D. Cal. Mar. 2, 1981); Federal Trade Commission Advisory Opinion to Burnham Hospital, at 6-7 (Feb. 24, 1983) (rejecting a tying analysis of an exclusive contract between a hospital and a physician group). In short, there is no authority whatsoever for characterizing an exclusive dealing agreement between a hospital and a physician group as a tying arrangement.

b. A factor which shows conclusively that the arrangement is not a tying agreement is that the patient is purchasing only one service—a surgical procedure. When a patient enters a hospital for surgery, he or she has no desire to use a surgical suite without a surgeon and anesthesia services, or anesthesia services without a surgeon and an operating room. Rather, a patient desires one product—the product of a unified episode of care in which the surgical suite, surgeon, and anesthesia services (and other services as well) are component elements.[4]

Curiously, while the Fifth Circuit properly recognized that a tying arrangement requires two products, neither it nor the district court examined whether, in fact, separate products were being sold. In its findings, the district court, without analysis, stated only that anesthesia services are separate from other hospital services. 513 F. Supp. at 540. That products are physically separate or separable, however, does not mean that they are distinct products for purposes of tying analysis. *See, e.g., Hirsh*, 674 F.2d at 1348. The Fifth Circuit noted only that

[4] Indeed, as the Fifth Circuit stated, 686 F.2d at 291, the patient normally does not even select the anesthesiologist. *See also* United States v. American Soc'y of Anesthesiologists, 473 F. Supp. 147, 160 (S.D.N.Y. 1979).

the instant case "deal[s] with two distinct services which a buyer should be able to obtain separately." 686 F.2d at 289. The court did not discuss why those services should be sold separately, and no evidence whatsoever supported that conclusion. Even where constituent parts could be or are sold separately, however, it does not mean that they must or should be. For example, stereo system components can be and are sold separately; but no one would argue seriously that a firm that combines and sells its components only as a system has engaged in an illegal tie-in. Moreover, if a client hires a particular law firm, no one would argue seriously that the firm is "coercing" its client illegally to purchase separate products if the partner in charge uses and bills for the products of that firm's associates, paralegals and secretaries.

The issue of product separability is especially important to hospitals because they provide, or contract for the provision of, a plethora of goods and services. Not only do they provide for the availability of physician and paraprofessional help as in this case, but hospitals also provide for numerous other goods and services without which the aggregate hospital services desired by patients could not be produced. Such items as blood, drugs, high technology equipment, food service, and laundry service are only a few. To mandate that a hospital allow its patients to choose the supplier of their choice would result in inefficiency if not utter chaos.

In attempting to solve the issue of product separability, the courts have used various language to describe what in effect is the same question: Does selling the products together promote quality and efficiency? *See, e.g., Hirsh,* 674 F.2d at 1347 ("[w]hether the aggregation serves to facilitate competition by promoting product quality"); *Principe* v. *McDonald's Corp.,* 631 F.2d 303, 309 (4th Cir. 1980), *cert. denied,* 451 U.S. 970 (1981) (one product where products are "integral components" or "essential ingredients" of the ultimate product); *Washington Gaslight Co.* v. *Virginia Electric and Power Co.,* 438 F.2d 248, 253 (4th Cir. 1971) (only one product where the

alleged tied product is an "ancillary and necessary" part of the package being sold). *See generally* R. Bork, *The Antitrust Paradox: A Policy at War with Itself* 371 (1978) ("[t]here is no doubt that this sense of efficiency is what is behind the law's attempt to decide whether a tying arrangement exists by determining whether one product or two are being sold").[5]

It is difficult, if not impossible, to find any case or commentator who argues that exclusive contracts between hospitals and physicians do not in fact achieve significant efficiencies.[6] Indeed, the offering of specialized anesthesiology services contracted for by the hospital as part of the surgical event necessarily involves quality and efficiency considerations.

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[5] Where, as here, the products are sold in fixed proportions rather than in variable proportions, both courts and commentators acknowledge that only one product is being sold. *See, e.g.*, Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L.J. 19, 21 (1957) ("[w]henever two products are used together in fixed proportions, such as one bolt and one nut, a cup and a saucer, or a left shoe and a right shoe, from a buyer's point of view the two together might as well be a single product"). The Ninth Circuit has recognized the importance of whether two products are used in fixed proportions by incorporating the question into its test for whether the arrangement involves separate products. *See, e.g.*, Siegel v. Chicken Delight, Inc., 448 F.2d 43, 48 (9th Cir. 1971), *cert. denied*, 405 U.S. 955 (1972); Klamath-Lake Pharm. Ass'n v. Klamath Medical Serv., [1983-1] Trade Cas. (CCH) ¶ 65,254 (9th Cir. 1983).

[6] *See, e.g.*, Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535 (1982); Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 Cum. L. Rev. 684, 702 (1979); M. Pollard & R. Leibenluft, *Antitrust and the Health Professions; Policy Planning Issues Paper* 96-99 (Federal Trade Commission, 1981); Federal Trade Commission Advisory Opinion to Burnham Hospital (Feb. 24, 1983); M. Thompson, *Antitrust and the Health Care Provider* 150-58 (1979); American Hospital Association, *Comments to the Federal Trade Commission on Exclusive-Source Contractual Arrangements Between Hospitals and Physicians* (Dec. 21, 1982) (attached as Appendix A).

and supports the conclusion that only one service is involved. The district court specifically found that the contract in this case achieved improved quality and efficiency, 513 F. Supp. at 540, and the Fifth Circuit's disagreement with this holding simply is not supported by the evidence.

In sum, the lower court erred by not examining whether one or two products were being sold and by not holding that patients purchase only one service—surgical procedures. By finding two products and thus characterizing the challenged agreement as a tying arrangement, the lower court improperly exalted form over substance.

III. The Fifth Circuit Erred In Applying The *Per Se* Rule To The Arrangement Because The Contract Is Not A Naked Restraint Of Trade

a. Quite apart from whether, as a technical matter, a hospital's surgical facilities and the anesthesia services available through it can be viewed as separate services, the court below erred in applying a *per se* standard of analysis. Exclusive contracts between hospitals and physician groups can, and the one in question did, result in a productively efficient and procompetitive type of partial vertical integration.

In recent years, this Court has taken pains to explain the narrow circumstances in which a *per se* analysis is proper. The Court has held that *per se* analysis should be used only where the practice in question is a "naked restrain[t] of trade with no purpose except stifling of competition," and thus "appears to be one that would always or almost always tend to restrict competition and decrease output," *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 19-20 (1979), as opposed to a practice "designed to increase economic efficiency and render markets more rather than less competitive." *Id.* (quoting *United States* v. *United States Gypsum Co.*, 438 U.S. 422, 441 n.16 (1978)).

In *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 50 (1977), this Court explained that "[*p*]*er se* rules ... are appropriate only when they relate to conduct that is manifestly anticompetitive." It recognized that non-price, vertical restraints normally achieve significant redeeming virtues relevant to the analysis here, such as the promotion of efficiency, protection from products liability claims, and increased competition.

Broadcast Music and *Sylvania* warn against the mechanical and wooden approach followed by the Fifth Circuit here of labelling a practice and applying *per se* analysis without first examining the practice's likely economic impact. In *Broadcast Music*, this Court cautioned against relying on "easy labels [which] do not always supply ready answers," noting that "[l]iteralness is overly simplistic and overbroad." 441 U.S. at 9. *See also Shop and Save Food Markets, Inc.* v. *Pneumo Corp.*, 683 F.2d 27 (2d Cir.), *cert. denied*, 103 S. Ct. 450 (1982) (applying these warnings to a tying case). In *Sylvania*, the Court emphasized that, in a case challenging a non-price, vertical restraint, "departure from the rule of reason standard must be based upon demonstrable economic effect rather than ... upon formalistic line drawing." 433 U.S. at 58-59.

In neglecting these explicit warnings and applying the *per se* rule, the Fifth Circuit rejected the evidence, the district court's findings, the standard applied by other courts and the unanimous opinion of commentators, and failed to weigh properly the enhancement to efficiency and quality which the exclusive contract achieved. The evidence showed, and the district court found, significant improvements in quality of care and efficiency flowing from the contract. 513 F. Supp. at 540.

b. Every federal court which has considered an exclusive arrangement, save the Fifth Circuit in the instant case, has analyzed it under the Rule of Reason and has rejected all attempts to attach the *per se* label to an arrangement consistently found reasonable after appropriate analysis of its effects.

In *Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976), the Fourth Circuit considered a Section 1 challenge to the hospital's exclusive arrangement for the provision of all radiology services at the hospital. The court found the challenge to be "frivolous," and remanded with instructions to dismiss the complaint "for want of a substantial federal question and a consequent lack of jurisdiction." *Id.* at 1134. *See also Capili, supra* (challenge to exclusive arrangement for provision of anesthesia services failed to show effect on interstate commerce; arrangement also was neither unreasonable nor arbitrary).

The Seventh Circuit Court of Appeals, in *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982), rejected an argument that the exclusive arrangement amounted to a group boycott or other *per se* violation, concluding instead that the case was "properly treated ... as one involving a vertical combination ... [which] ... must be analyzed under the Rule of Reason." *Id.* at 1352, *citing, e.g., Tampa Electric Co., supra.* Further in concluding that it had "serious question whether plaintiff ... demonstrated a reasonable likelihood of success on the merits," and thus that the preliminary injunction should be vacated, the Seventh Circuit adopted for purposes of its analysis the reasoning of the *district* court in the instant case, noting with "particular interest" that court's conclusion as to the relevant geographic market and its findings concerning the procompetitive effects of exclusive contracts. 684 F.2d at 1353-54.

Finally, in *Smith* v. *Northern Michigan Hospitals, Inc.*, [1983-1] Trade Cas. (CCH) ¶65,289 (6th Cir. Mar. 25, 1983), the Sixth Circuit affirmed a lower court judgment that a hospital's exclusive contract for emergency room services did not violate Section 1. The court held that the hospital, as the coordinator and supplier of an essential public service, was properly viewed as standing in a vertical relationship both to the contracting physicians and to the independent physicians in the service area. The court thus undertook an appropriate

balancing of what it deemed the "undisputedly legitimate financial and medical reasons" for the staffing arrangement against any "ancillary" adverse effects on practitioners, in the course of affirming judgment for the hospital on the Section 1 claims. *Id.* at 69,708. *See also Valley Hospital Medical Center Foundation, supra.*[7]

Commentators reach the same conclusion.[8] The hospital has a substantial and independent interest in who provides ancillary services to ensure quality and availability, as well as to reduce costs. "[T]he existence of substantial hospital-owned equipment and numerous hospital employees who are supervised by the physicians would appear to create a prima facie case that the hospital has a strong independent interest at stake and should be allowed to manage its affairs as it wishes." Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 665 (1982). *See also* Feldstein & Roehrig, *Medical Staff: Closed v. Open Staffing—What's at Stake?*, Hospitals (J. Am. Hosp. Ass'n), Jul. 16, 1982, at 97 (the fewer the physicians, the easier it is for a hospital to control quality).

c. In sum, exclusive contracts achieve significant quality and efficiency benefits of the type recognized by the antitrust laws, and thus prior decisions of this Court preclude application

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[7] Further, the Fifth Circuit's analysis also conflicts with decisions of the Third and Sixth Circuits, which, although involving staffing arrangements not exclusive in nature, raised similar antitrust issues, and in which Rule of Reason analysis was deemed appropriate. *See* Stella v. Mercy Hospital, No. 82-1274 (6th Cir. Oct. 25, 1982), *cert. denied*, 51 U.S.L.W. 3747 (U.S. Apr. 19, 1983); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir.), *cert. denied*, 103 S. Ct. 302 (1982). *See also* Pontius v. Children's Hospital, No. 78-987 (W.D. Pa. Dec. 20, 1982); Pao v. Holy Redeemer Hospital, 547 F. Supp. 484 (E.D. Pa. 1982).

[8] *See* note 6 *supra.*

of the *per se* rule however the agreement is characterized.[9] Indeed, the economic impact of the agreement in question here is similar to that of the agreement challenged in *Sylvania*, where this Court explained that, although intrabrand competition might be adversely affected, interbrand competition would be strengthened. In this case, the agreement may reduce the number of anesthesiologists *at this hospital* below what it might otherwise be;[10] on the other hand, the contract's effect on quality and efficiency inure to the benefit of patients and makes the hospital a more effective competitor in the market.

Accordingly, the *per se* rule simply is not applicable to an arrangement where a facial examination reveals potentially significant procompetitive effects such as those resulting from

[9] One of the most unusual aspects of the Fifth Circuit's decision is its emphasis on the hospital's use of nurse anesthetists as an anticompetitive rather than a procompetitive factor. 686 F.2d at 291 & n.8. Clearly, efficiency is enhanced when lower-cost resources are used, and no evidence exists that quality is lowered. *See Is HHS Deadening the Pain of Competition?*, Regulation, Jan./Feb. 1983, at 11. Indeed, a primary overall benefit achieved by use of exclusive arrangements, and recognized by numerous courts and commentators that have considered the issue, is the *enhancement* of quality. *See also* discussion at Section I *supra*.

[10] This was the Fifth Circuit's basis for finding that the contract was anticompetitive. 686 F.2d at 291-92. The court found two anticompetitive effects: First, anesthesiologists were excluded from "that part of the anesthesia services market which the hospital controls." *Id.* at 292. This rationale improperly reflects an overriding concern with competitors rather than competition. *See, e.g.*, Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977). Furthermore, if the hospital's share of the market is not substantial, any effect on competition is *de minimis*. A second anticompetitive effect, according to the court, was that patients were unable to choose among different anesthesiologists. 686 F.2d at 292. This "buyer autonomy"-type of purported anticompetitive effect was specifically rejected by *Sylvania*. *See* 433 U.S. at 53 n.21. *See also* Hirsh v. Martindale-Hubbell, Inc., 674 F.2d 1343, 1349 n.19 (9th Cir.), *cert. denied*, 103 S. Ct. 305 (1982).

the vertical integration here.[11] The Fifth Circuit erred in failing to recognize and properly weigh these benefits.

IV. The Fifth Circuit Erred In Holding That The Hospital Had Sufficient Economic Power In The Market For The Alleged Tying Product To Restrain Competition In The Market For The Alleged Tied Product

a. As the court below recognized, 686 F.2d at 286, the vice of tying arrangements "is the wielding of monopolistic leverage; a seller exploits his dominant position in one market to expand his empire into the next." *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594, 611 (1953). On the other hand, as Justice White explained in *Fortner Enterprises, Inc.* v. *United States Steel Corp.*, 394 U.S. 495 (1969) (*Fortner I*), "it is not all tying transactions in general, but only those where leverage in one market has been used to distort another which so far have been held illegal restraints of trade." *Id.* at 517 (White & Harlan, JJ., dissenting). The use of leverage is the economic factor which distinguishes a tying arrangement from an ex-

[11] This Court's decision applying the *per se* rule to a maximum price-fixing agreement among competing physicians in Arizona v. Maricopa County Medical Soc'y, 102 S. Ct. 2466 (1982), does not mandate application of the *per se* rule here. *Amicus'* argument is not, as in *Maricopa*, that the health care sector is "different" and thus that different rules should apply (although as explained in Section IV, *infra*, the court below improperly applied a "different" analysis in determining the geographic market). Rather the argument here is that, even if two products are involved, a tying arrangement exists only in form rather than effect. *See Broadcast Music, supra.* The agreement in question here achieves the type of integration missing in *Maricopa* by resulting in a product different from that produced by the parties individually. Because the parties to the agreement are not competitors, the anticompetitive potential of the arrangement, unlike that in *Maricopa*, does not justify facial invalidation. *See* 102 S. Ct. at 2475 n.18. Indeed, the only arguable rationale for applying the *per se* rule here is judicial efficiency, a justification that this Court specifically rejected in *Sylvania*, 433 U.S. at 50 n.16.

clusive dealing contract, and thus is the only justification for applying the *per se* rule to any tying arrangement. *See, e.g., Warner Management Consultants, Inc.* v. *Data General Corp.*, [1982-83] Trade Cas. (CCH) ¶ 65,062 (N.D. Ill. Aug. 16, 1982); Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L.J. 19, 34 (1957) ("[a]nalytically, the per se rule demands a prior finding of leverage").

Leverage denotes the seller's creation of monopoly power in the tied product market through the use of power in the market for the tying product. The seller must be able to restrict output in the market for the tied product, and this cannot occur where, as here, the products are used in fixed proportions. *See, e.g.*, Bowman, *supra*, at 20, 23.[12] In this case, the products indeed are complements and used in fixed proportions, and what evidence there was suggested that output was not restricted. The Fifth Circuit specifically held that the exclusive contract did not increase the price for the tied product—anesthesia services—and thus output was not restricted. 686 F.2d at 291.

b. To exercise leverage and thus trigger application of the *per se* rule, a firm must have some degree of market power with respect to the tying product. *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (*Fortner II*), read together with *Fortner I, supra*, establish that a firm must have "appreciable economic power" in the market for the tying product before the *per se* rule is applicable. *Fortner II*, 429 U.S. at 611-12. In determining whether the seller has such power, the crucial question is "whether the seller has some advantage not shared by his competitors in the market for the tying product." *Id.* at 620. To prove "appreciable economic power" in the market for the tying product, a plaintiff must show that (1) the seller occupies a dominant position in the market, *Northern Pacific Railway Co.* v. *United States*, 356 U.S. 1 (1958); *Fortner I, supra;* (2) the tying product is

[12] *See also* note 5 *supra.*

sufficiently unique that it provides the seller with a significant competitive advantage over its competitors in the market for the tying product, *Fortner I, supra; Fortner II, supra;* or that (3) a substantial number of customers accepted the tie-in, and the seller's economic power is the only explanation for their doing so.[13] *Northern Pacific Railway Co., supra; Fortner II, supra. See generally United States* v. *Mercedes-Benz of North America, Inc.*, 517 F. Supp. 1369, 1384 (N.D. Cal. 1981).

The plaintiff appeared to rely on, and both lower courts analyzed, only the first indication of potential economic power—a dominant position in the market. There was no evidence regarding why any patients accepted the arrangement or that they objected to it;[14] and Dr. Hyde made no attempt to show that any of the Petitioner's services (much less its surgical facilities) were in any way unique or that the hospital had any competitive advantage over any other hospital on the east banks of Jefferson and Orleans Parishes. Indeed, the district court specifically found that the Petitioner had no such advantage, 513 F. Supp. at 540, and the Fifth Circuit did not address the issue.

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[13] The fact that many customers accept the two products together actually says little with respect to whether a firm has appreciable economic power because so many reasons can lead to acceptance. These include dealer or customer preference, low price, high quality, location, custom or any other factor upon which consumers base purchasing decisions. Thus, while market power is necessary to coerce purchasers to accept the package, the fact of acceptance is not inconsistent with little or no market power. *See generally* P. Areeda, *Antitrust Analysis: Problems, Text, Cases* ¶ 530, at 733 (1981).

[14] In this case, the reason that patients accepted the arrangement could be that patients do not choose the anesthesiologist, relying instead on the hospital, and that they are perfectly happy with the hospital's choice. *Cf.* Ungar v. Dunkin' Donuts of America, Inc., 531 F.2d 1211, 1218 (3d Cir.), *cert. denied*, 429 U.S. 923 (1976) ("[i]f the product in the second market would be accepted anyway, because of its own merit, then, of course, no leverage is involved").

c. The burden on the Respondent was then to show that the Petitioner had a dominant position in the market for surgical facilities or at least that it had sufficient power to engage in leverage. *See Fortner I*, 394 U.S. at 519 (White & Harlan, JJ., dissenting) ("[t]his evil simply does not exist if there is no power in the first market); *Warner Management Consultants, Inc., supra*, at 70,964 ("where there is no injury which reflects the presence of market power, the dangers associated with tying are absent and there is no justification for *per se* condemnation").

A firm has market power only if it can raise prices or decrease quality without losing significant numbers of customers. *See, e.g.*, Landes & Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937, 937 (1981). As the Fifth Circuit properly recognized, the relevant geographic market had to be delineated before the hospital's power could be assessed. 686 F.2d at 289. *See also United States* v. *Jerrold Electronics Corp.*, 187 F. Supp. 545 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961). If patients residing in the purported geographic market readily travel to hospitals located elsewhere, a hospital in that market cannot exercise market power, and the area in question cannot be a relevant geographic market. *See generally* 2 P. Areeda & D. Turner, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* § 5C, at 347-70 (1978).

d. The Fifth Circuit's analysis and conclusion regarding the relevant geographic market was a fundamental error in deciding this case. The court implicitly recognized, correctly, that the geographic market is "the area of effective competition" where "the seller operates, and to which the purchaser can turn for supplies." *Tampa Electric Co.*, 365 U.S. at 327. Nevertheless, the court ignored what little evidence there was on the issue (which was introduced by the Petitioner rather than by Dr. Hyde) and engaged in a unique and puzzling analysis which has no support in the record, in logic or in law.

A geographic market can be determined by examining the locations of firms with whom purchasers deal. Where a significant number of residents of a purported geographic market deal with firms located outside of that area and where residents of other areas deal with firms located in the purported market, the area in question cannot be a relevant geographic market. *See generally* Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 Antitrust Bull. 1 (1978). Residents of the purported market can and do purchase elsewhere, and firms outside the purported market clearly constrain the competitive behavior of firms inside, preventing them from exercising market power. If a firm (or all firms) within the purported market attempted to exercise market power by raising its prices, decreasing quality or tying the sale of an unwanted product or service, customers could and would deal elsewhere. *See generally* Werden, *The Use and Misuse of Shipments Data in Defining Geographic Markets*, 27 Antitrust Bull. 719 (1981).

The evidence showed that 70 percent of hospital patients residing on the east bank of Jefferson Parish used hospitals other than the Petitioner and that 30 percent of the Petitioner's admissions were patients residing in areas other than the east bank of Jefferson Parish. 513 F. Supp. at 540, 542; 686 F.2d at 289-90. Based on this evidence, the district court clearly was correct in holding that the relevant geographic market consisted of at least all east bank hospitals in Jefferson and Orleans Parishes, 513 F. Supp. at 542-43; and the Fifth Circuit clearly erred in holding that the geographic market consisted only of the east bank of Jefferson Parish. 686 F.2d at 289-91. The Fifth Circuit below in fact appeared to recognize implicitly that the geographic market actually is larger than the east bank of Jefferson Parish alone, conceding that a "traditional method of economic analysis," 686 F.2d at 290, would lead to the district court's conclusion; indeed, the court conceded that "[u]nder the analysis applied to a truly competitive market, [Dr. Hyde] has failed to prove an illegal tying arrangement." *Id.*

To circumvent the traditional manner of delineating geographic markets, the Fifth Circuit held that, because patients select the hospital closest to home, the market is the east bank of Jefferson Parish where the Petitioner is located. It reached this conclusion by assuming that patients favor public, non-profit hospitals such as the Petitioner because third-party payment insulates patients from price considerations and patients lack information regarding the quality of care provided at different hospitals. The court also relied on a Louisiana statute which directs the hospital to provide care in the east bank of Jefferson Parish, assuming that this somehow aided in geographic market delineation.

This analysis is riddled with unsupported assumptions and non sequiturs. First, the only evidence in the record on the issue of geographic market definition belies the Fifth Circuit's conclusion. As noted above, it showed significant passage of patients into and out of the purported market. For whatever reason this occurs, the fact that it does occur is totally inconsistent with the Fifth Circuit's conclusion. Second, even if third-party payment does render patients less sensitive to a hospital's charges than they otherwise would be, this means only that other variables, such as quality, are the focus of competition; it does not render traditional market analysis inapplicable. *See, e.g., Robinson* v. *Magovern*, 521 F. Supp. at 878-86 (substitution of quality for price as primary competitive variable; geographic market consisting of 16 counties and numerous hospitals).

Third, even if patients have less information about hospital quality than about the quality of other services they purchase, physicians have such information and can and do aid patients in hospital selection.[15] *See generally* P. Feldstein, *Health Care Economics* 84-90 (1979). Thus, just as the location of a supplier is a factor which customers weigh in determining with

[15] If patients are as uninformed as the court below surmised, then it is unlikely that they know which hospitals are public or non-profit, and thus it is unlikely that the hospital's status provides it with any competitive advantage.

whom to deal when purchasing any good or service, it may be a factor that patients consider in choosing a hospital. As in the case of other purchases, however, patients consider other variables as well, including quality, reputation and technological capacity. *See* American Hospital Association, *Comments to the Federal Trade Commission on Exclusive-Source Contractual Arrangements Between Hospitals and Physicians* (Dec. 21, 1982) (attached as Appendix A). The Fifth Circuit's conclusion, carried to its logical extreme, holds that every hospital literally is a monopoly. Practical reality in general, and the statistics in the record of this case in particular, show that this assumption is false.

Finally, the court below interpreted La. Rev. Stat. Ann. § 46:1055, which directs the hospital "[t]o represent the public interest in providing hospital and medical care in the district," as a mandate that the hospital "serve only the East Bank of Jefferson Parish." 686 F.2d at 291. But the statute, which patently *does not* restrict whom the hospital can serve, is wholly irrelevant to delineation of the geographic market. In no way does it constrain patients residing on the east bank of Jefferson Parish from choosing a hospital in Orleans Parish or patients from elsewhere from using the Petitioner, as the court below evidently assumed. The statistics show this conclusively. Geographic market definition is not a function of arbitrary, political boundaries but rather a function of economic variables, including where patients do obtain, and can obtain, the service in question.

In sum, the Fifth Circuit's geographic market definition was clearly erroneous. As that court itself properly recognized, destruction of that foundation destroys as well the court's conclusion: Under a "traditional method of economic analysis," Dr. Hyde "has failed to prove an illegal tying arrangement." *Id.* at 290. Without the improperly narrow and unique market definition constructed by the court below, there can be no basis for the Fifth Circuit's decision that the hospital has appreciable economic power.

CONCLUSION

The economic environment of health care is changing through public and private policy initiatives. The direction of these changes is such that increased application of antitrust law to health care may be anticipated. Those in the health field believe that well-reasoned application of the law is imperative to avoid needless and harmful disruption of critical patient care arrangements. To this end, and for the foregoing reasons, it is respectfully submitted that the judgment of the United States Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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APPENDIX A

December 21, 1982

Carol Thomas, Secretary
Federal Trade Commission
Washington, D.C. 20580

Dear Mr. Thomas

Through Mr. Arthur N. Lerner, Assistant Director of the FTC's Bureau of Competition, the American Hospital Association has been invited to comment on a matter pending before the Commission. Pending is a hospital request for an advisory opinion on an exclusive arrangement between the hospital and a physician group for the delivery of diagnostic radiology services to patients at the hospital.

The name of the hospital requesting the opinion has not been disclosed by the Commission's staff to AHA, but we have been assured that the hospital welcomes the submission of comments by the Association.

We understand the following: The hospital requesting the opinion is a general acute care facility in a medium-sized city. It is one of four hospitals operating in its area that offer a similar range of services, each of which has an exclusive contract with a different group of radiologists. The subject hospital has entered into a contract with a physician group that grants the group the exclusive right to provide diagnostic radiology services in the hospital. The group supervises the

radiologic technicians employed by the hospital and provides other administrative services to the radiology department. The physicians and the hospital bill patients independently for their services. The contract is for an initial term of three years and is renewable thereafter on an annual basis.

In response to Mr. Lerner's invitation, the American Hospital Association submits the enclosed comments concerning exclusive-source arrangements between hospitals and physicians. The AHA is the primary organization representing the nation's hospitals, with 6,300 institutional and 35,000 personal members.

Because the AHA does not have before it all of the particular facts and circumstances surrounding the subject arrangement, our comments do not draw a specific conclusion on the matter. Such facts as are known to us do not suggest an anticompetitive intent or outcome.

Our comments, moreover, do emphasize that there are compelling justifications for exclusive-source arrangements which are consistent with enhanced competition in the hospital and medical care marketplace. The AHA believes that the right to enter into such arrangements is important to hospitals and supports the right of a hospital to make such an arrangement in the interest of the best patient care.

If the Commission has any questions on these comments or would like any additional information, please contact me directly. The AHA very much appreciates the opportunity to present its views on this subject.

Sincerely

/s/ RICHARD L. EPSTEIN
Richard L. Epstein
Senior Vice President

mm
enc.
cc: J. Alexander McMahon
President, American Hospital Association
Arthur N. Lerner
Assistant Director, FTC Bureau of Competition

AMERICAN HOSPITAL ASSOCIATION'S COMMENTS TO THE FEDERAL TRADE COMMISSION ON EXCLUSIVE-SOURCE CONTRACTUAL ARRANGEMENTS BETWEEN HOSPITALS AND PHYSICIANS

General

During the past twenty years, hospitals increasingly have utilized exclusive arrangements with physician specialists to staff hospital departments, although the scope and nature of such arrangements vary widely. Medical specialties commonly offered through exclusive-source arrangements include anesthesiology, emergency care, pathology, and radiology. In addition, reflecting the growing specialization and increasing technological sophistication of medical care delivery, such hospital-based specialties as nuclear medicine, renal dialysis, cardiac catheterization, cardiac surgery, and major surgery, among others, have become frequent subjects of exclusive contracts between hospitals and physicians.

The American Hospital Association recognizes that medical care is being provided in hospitals by physicians under many forms of mutual agreement and does not advocate any specific manner of providing hospital or medical services as the best in any particular case. However, AHA supports the right of each hospital to make its own reasonable professional decisions in this area and recognizes that an exclusive-source arrangement between a hospital and a physician or group of physicians may serve important interests of the hospital and the community and confer significant benefits on patients, without adverse effect on (and often with enhancement of) competitive outcomes in the health care marketplace.

The Market For Hospital Care

To fully appreciate the potential benefits of exclusive source arrangements, it is important to recognize some of the unique aspects of the market for medical care and hospital services.

Foremost among these considerations is the relatively small degree of traditional price competition in the hospital marketplace confronting patients (and their physicians). Through either public (e.g., Medicare, Medicaid, and local assistance programs) or private health insurance, more than 90 percent of the American population is effectively insulated from most or all of the price of hospital care. This situation reflects conscious public policy in favor of health insurance protection implemented through entitlement programs, such as Medicare, and through tax subsidies for employers, employees and other individuals who receive or purchase health insurance benefits.

As a consequence of this situation, non-price factors have been the major parameters of competition among hospitals. Recent studies demonstrate that quality, reputation, and technological capacity are the prime determinants in the selection of a hospital by patients and by physicians, far outweighing other considerations such as geographic proximity.

At the same time, the absence of a price-competitive consumer marketplace does not signify a complete absence of pressures on hospitals and the public to control health care costs and improve hospital efficiency. Third-party payers (federal and state government, Blue Cross, and commercial health insurers) historically have used coverage policies and regulatory controls to promote more efficient use of high-volume ancillary services (e.g., radiology, pathology) and of high-cost, advanced-technology procedures. More recently, these payers have sought a complete restructuring of hospital payment systems in order to impose some measure of price competition on their "marketplace" for hospital services. For example, the Tax Equity and Fiscal Responsibility Act of 1982 created a system of Medicare cost limits for each hospital's total cost per discharge, a departure from Medicare's historical payment on the basis of cost per unit of service. This change is intended to provide a groundwork for a future Medicare payment system based on a prospectively-determined price per discharge, a direction in which other third-party payers also are moving.

Therefore, while consumers remain insulated from the cost consequences of their utilization decisions and from the dynamics of the changing hospital payment system, hospitals today must achieve more complete resource management, through control of volume and service utilization and through improvement of productivity, while maintaining the quality of services delivered. Obviously, because the hospital is not a practitioner of medicine, its relationships with physicians are of critical importance to a successful response.

Finally, it must be noted that the financial insulation of the consumer, in combination with the growing sophistication of medical care, has placed upon the hospital an increasingly broad legal obligation to ensure both the availability and the quality of needed hospital services. The expansion of this obligation has eliminated many of the legal distinctions between the hospital and the independent contractor-physician who practices within the institution that in the past shielded the hospital from the legal consequences of the physician's actions.

Potential Benefits of Exclusive Source Arrangements

Hospitals (and various courts presented with the issue) have identified numerous patient care and administrative benefits flowing from exclusive contractual arrangements. In general, a hospital seeks to ensure the constant availability of consistent, high quality, specialized administrative and professional services at a reasonable cost. This goal is particularly important with respect to those hospital-based ancillary services that indeed are most commonly the subject of exclusive arrangements—radiology, pathology, anesthesiology, and emergency room services.

These ancillary services are those that a hospital must—by virtue of licensure regulations, Medicare participation requirements, voluntary accreditation, and professional liability standards—guarantee as available to all patients using the hospital. Because patients typically do not select the physicians rendering these services, the hospital has a greater (and judicially-recognized) burden of responsibility in assuring the proper

quality and quantity of such services. By means of the exclusive contract, the hospital is better able to monitor the performance of a physician or physician group and, if dissatisfied, to terminate the arrangement on short notice and contract with others.

Other specific benefits identified with exclusive source arrangements include:

—Standardization of procedures within a hospital department in order to achieve reduced operating costs and to better assure consistency of outcome.

—Improved performance monitoring to assure that medical quality standards are being met. This result flows from standardization of procedures and the establishment of a single point of accountability for professional services in the department.

—More effective selection, maintenance, and utilization of equipment. Under an exclusive arrangement, the hospital and the contracting physicians have a mutual interest in the cost-effective use of expensive technology. This is not necessarily the case if the hospital merely serves as a "workshop" for the diverse interests of many independent practitioners.

—Relatedly, better scheduling in the use of facilities and support staff. Work is best done if the use of services is planned in advance. Such planning typically is a contractual obligation of the contracting physician or group and is simplified when coordinated through a sole source.

—Better work routines and teamwork, attributable to the fact that physicians, nurses, and technicians work together consistently. Also, supervision and training of departmental personnel is improved. The contracting physicians obtain the benefits of a division of labor, and have the ability and responsibility to pool knowledge and skills.

—Greater physician competence, due to increased specialization and the enhancement of skills through repetition of specialized procedures.

Quality standards in many areas of medical practice specify a minimum volume of procedures necessary to ensure continued proficiency.

—Contractual provision of a unified responsibility for the subject service, establishing a point of accountability for the hospital's administration and governing body. This contractual responsibility and accountability assists the hospital to discharge its ultimate responsibility, imposed by Medicare participation requirements, voluntary accreditation, and common law, for the composition and services of its medical staff.

—Higher commitment among the physicians to the efficiency and quality of the institution.

—An enhanced reputation for excellence, enabling the hospital to attract and retain highly-qualified medical staff members in all disciplines. This consideration is particularly important given the increasing willingness of courts to hold hospitals responsible for the competence of physicians granted staff privileges.

Effect on Competition and Legal Characterization

The typical hospital-physician exclusive privileges arrangement is largely analagous to an exclusive distributorship agreement in a commercial setting. The hospital simply decides with whom it will contract to provide services to the public. Thus, these arrangements typically involve vertical, rather than horizontal, lines of commerce, and are analyzed under the "rule of reason." Accordingly, the balancing of procompetitive benefits against anticompetitive effects is necessary to determine the reasonableness, and legal status, of any particular exclusive-source arrangement.

Courts presented with challenges to such an arrangement have inquired into the characteristics of the relevant local market, the

purpose motivating the arrangement, its duration, the manner in which the decision was made to utilize the arrangement, whether it sprang from anticompetitive or exclusionary interest, and the benefits to the hospital and its patients from the arrangement.

Despite the wide variety of market characteristics and contract terms, the courts have been virtually unanimous in upholding exclusive-source arrangements.* Failure to demonstrate injury to competition has been reflected in judicial findings that:

—individual hospitals lack a dominant position in the market;

—the arrangements have not been executed for the purpose of injuring competitors but rather for the purposes of assuring quality and enhancing efficiency;

—such restraints that may have resulted from the agreement have been reasonable in scope and duration; and

—on balance, competition among physicians and among hospitals has been promoted by the arrangements.

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* The one departure from the long line of decisions upholding exclusive arrangements, and apparently the only decision to apply *per se* analysis to such an arrangement, is the recent decision in *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982), holding an exclusive contract for anesthesiology services to constitute a *per se* illegal tying arrangement. Because of the uniqueness of this decision, it is appropriate to point out certain erroneous departures in its reasoning.

—First, the tie-in doctrine is inapplicable where the arrangement *defines* the product the hospital sells. Ancillary services, such as anesthesiology, pathology, and radiology, are integral to the hospital's product: an episode of patient care. The U.S. Supreme Court has rejected the approach of defining a tie by looking for *potentially* severable items within a larger product. *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594 (1953).

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In this last respect, courts have paid careful attention to the fact that the quality of medical services and reputation of the hospital are important determinants of competition in medical care.

Accordingly, the courts have identified procompetitive benefits stemming from the hospital's enhanced ability to select qualified staff, improving the institution's ability to compete with others and raising the level of care in the community. A recent U.S. Court of Appeals decision described this effect on quality, and its implications for competition among physicians, as follows:

> "A closed department may enhance competition among hospitals in the marketplace by increasing the quality of care available. It may also serve to benefit competition among [physician] groups if the terms of the contract are not for unreasonable periods of time. Such a system would

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— Relatedly, it is not clear that patients or their physicians are appropriately viewed as the purchasers of these ancillary services. In view of the hospital's legal responsibility for assuring the quality and availability of such services for its patients, its potential liability for negligent rendition of those services, and its potential liability for negligently granting staff privileges, the hospital more appropriately may be characterized as the purchaser. [*See Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982).] Under such circumstances, questions of tying are irrelevant.

— Finally, the *Hyde* court was in error in rejecting the conclusion of the district court that the relevant market was no smaller than a (limited) geographic area within which the hospital served approximately 30 percent of the total number of hospital patients (and, which area the hospital was required to serve by state law). In so doing, the Fifth Circuit erroneously ignored the variety of factors (and in particular, quality of care) which lead patients and physicians to choose a hospital, the large supply of hospital facilities in the area, and the extent to which physicians in the community have medical staff privileges at multiple facilities. Moreover, if the hospital rather than the patient is viewed as the purchaser of these services, the market clearly is larger than the Fifth Circuit determined.

> serve to encourage [physicians] to improve the quality of their services in order to obtain these contracts with hospitals." *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, supra.* (*See also Robinson v. Magovern,* 521 F. Supp. 842 (W.D. Pa. 1981).)

The AHA believes that improved patient care and resource management, as well as enhanced quality competition among hospitals, in fact result in the large majority of cases where hospitals have elected to utilize exclusive-source arrangements. Of course, a variety of factors, including peculiar local market characteristics, may serve to invalidate a particular contractual arrangement under rule of reason analysis. However, the AHA believes that the vertical nature of these agreements, combined with compelling management and professional quality justifications, weigh heavily in favor of their validity under the antitrust laws.

Application to Radiology Services

Diagnostic radiology services are an integral part of the inpatient operations of a hospital. Advances in technology have expanded the applications of diagnostic radiology in emergency services, pre-admission testing, and inpatient care. Further, patients and their attending physicians demand (and courts and regulators require) that hospitals ensure the quality and availability of this routinely necessary ancillary service. Accordingly, and as explained in detail above, a very significant number of hospitals have utilized the exclusive contractual arrangement as the means to ensure the necessary quality and availability of this service.**

The hospital, in addition, has a specific interest in the effective management of the radiology department—one that also can

** Although exact data on the prevalence of exclusive contractual arrangements is not available, a recent study conducted by the Health Care Financing Administration reports that, in 1977, 86.3 percent of hospital-based radiologists provided services under contractual relationships with one or more hospitals. (HCFA-NORC Survey of Physician Practice Costs and Incomes, 1977.)

be served directly by an exclusive contractual arrangement. Control of unnecessary x-ray utilization, as well as effective supervision of radiologic technicians, contributes to a reduction of professional liability risks and to the institution's ability to contain costs and to respond to pressures exerted upon it by third-party payers. Significantly, therefore, enhanced quality and management effectiveness in this critical support service improves the individual hospital's competitive position among the community and its medical practitioners. Moreover, the opportunity to obtain exclusive contractual rights from a hospital to provide radiologic services, in many parts of the country, will stimulate competition among radiologists in a broad, often multi-state, market.

Conclusion

Although the absence of detailed information concerning the particular fact situation before the Commission does not enable the AHA to reach a specific conclusion in this matter, such facts as are known to us suggest the existence of circumstances which would render the arrangement reasonable under federal antitrust laws. The AHA believes that there are compelling justifications to uphold the right of a hospital to enter into exclusive-source contracts when it finds that such arrangements are in the best overall interests of patient care.

[These comments submitted under cover letter dated December 21, 1982, in response to a request from the Commission.]